

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12661

Reg. Dist. No. 284

1. PLACE OF DEATH:

County St. Marys
 City or town Charlotte Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Marys
 City or town Charlotte Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

ROSE SOMERVEILLE BUNTING

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 3 1856 6. (c) If alive, give age _____ years

8. AGE: Years 89 Months 9 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
none

10. Usual occupation _____

11. Industry or business _____

12. Name Rev. Dr. James Bunting13. Birthplace Maryland14. Maiden name Jane Eleanor Shemwell15. Birthplace Maryland16. Informant Miss Eleanor CanterAddress Charlotte Hall, Md

17. Burial Burial Date thereof 12-8-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel M.E. CemetryLocation Near Budds Creek, Md.18. Funeral director Elmer M. quadeAddress Hughesville, Md.

19. 12-7- 45 Eleanor S. Canter
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 45 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 26th 1945 to Dec 6th 1945and that I last saw him alive on Nov 27th 1945

Immediate cause of death _____ DURATION _____

Mitral Insufficiency 2 pr.

Due to _____

Due to _____

Other conditions Old ageGen. physical degeneration
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Levin J. Soshon M. D. or other _____Address Charlotte Hall Md Date signed 12/7-45

RECEIVED

DEC 12 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

286

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

B.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

46

R.V. Calum

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

12-30-1946 at 2:15 P

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

1946, to 12-16-1946

and that I last saw him alive on 12-16-1946

Immediate cause of death

chronic

infectious

DURATION

10 yrs

Due to

chronic rheumatism

Due to

Other conditions

ben. debility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert V. Calum

M. D. or other

Address

Baltimore Md.

Date signed 1-1-47

RECEIVED

JAN 4 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 281

12663

1. PLACE OF DEATH:

County St. Mary's
City or town Rural. St. Ingoes
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town St. Ingoes
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

James Chisley

3. (b) Social Security Number

4. Sex M 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Maggie Chisley (Deceased)

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1874 B. (c) If alive, give age years

8. AGE: Years 71 Months 1 Days 7 If less than one day hrs. min.

9. Birthplace Great Mills St. Marys Co.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name Do not know

13. Birthplace

14. Maiden name Do not know

15. Birthplace

16. Informant Harold Miles

Address St Ingoes md.

17. Buried Date thereof 12-24-45
(Burial, cremation, or removal. Where? (month) (day) (year))

Cemetery or crematory St. Peter's Church

Location

18. Funeral director E. L. Robinson

Address Dameron Md

19. Dec 22 1945 Registrar P. Pearson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 19 45 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5 19 45, to 12-21 19 45
and that I last saw him alive on 10-5-45 19 45

Immediate cause of death

Carcinoma of Liver

Due to Carcinoma - Stomach

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. Pearson M. D. or other

Address Pearson Md Date signed 12-22-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 27 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12664

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Mary'sCity or town Rumney, Abell
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15-7-45

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary'sCity or town Rumney, Abell
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Ernest Ellis

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Esther Ellis8. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) 6-10-18768. AGE: Years 69 Months 6 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace Abell, St. Mary's, MD
(Town, county, and state)10. Usual occupation Operator & Hammer

11. Industry or business

12. Name Charles Ellis13. Birthplace Abell, MD14. Maiden name Josephine Chaudoin15. Birthplace St. Mary's Co, MD16. Informant Esther m EllisAddress Abell, MD17. Burial Date thereof 12-6-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation Baltimore, MD18. Funeral director M. C. Mattingly & SonAddress Lombard St19. 12-5- 1945 R. V. Palmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3- 1945 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him/her alive on _____ 1945Immediate cause of death pericardialapoplexyDue to chronic myocarditis

Due to _____

Other conditions Had pneumoniaJan. 1945

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

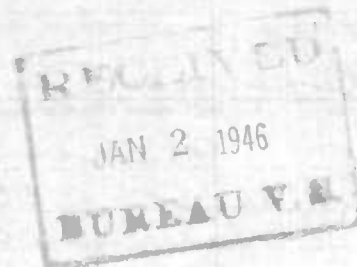
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. Palmer

M. D. or other _____

Address Abell, MD Date signed 12-5-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
 County St. Marys
 City or town Levinston Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State R. Maryland County Sancti Spiritus
 City or town Levinston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 312 S. Harrison St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME John E. Green

3. (b) Social Security Number

579-18-8769

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced UNKNOWN

8. (c) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) 1905 8. (c) If alive, give age years

8. AGE: Years 40 Months — Days — If less than one day
 hrs. min.

9. Birthplace unknown
 (Town, county, and state)

10. Usual occupation unknown

11. Industry or business —

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Found among his effects & S. Park

Address other paper

17. (Burial, cremation, or removal, Which?) Rural Date thereof 12-22-45
 (month) (day) (year)

Cemetery or crematory C. L. H. Alma House Farm

Location near Levinston Ind.

18. Funeral director W. C. Brattley Sons

Address Levinston Ind.

19. Date rec'd by registrar Dec 22 1945 Registrar Green

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945 at 24

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18th 1945

and that I last saw him on couch

Immediate cause of death Freezing from Exposure

DURATION few hours

Due to Alcoholic Indulgence

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Brattley Sons M. D. or other

Address Levinston Ind. Date signed 12-18-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WESTLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED

DEC 26 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

12666

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
3 years
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P. F. D. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Robert Paul Greenwell

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mabel E. Greenwell
 7. Birth date of deceased (mo., day, yr.) Sept 7 - 1890 6. (c) If alive, give age 47 years
 8. AGE: Years 55 Months 3 Days 6 It less than one day
5-5-36 hrs. min.

9. Birthplace Leonardtown St. Mary's Maryland
 (Town, county, and state)

10. Usual occupation Summer man

11. Industry or business

12. Name Paul Greenwell
 13. Birthplace Leonardtown Md
 14. Maiden name Lucie M. Wether
 15. Birthplace Leonardtown Md

16. Informant Robert Paul Greenwell
 Address 1100 Holbrook Avenue N.E.

17. Burial Washington Dec 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Albans
 Location Leonardtown Md

18. Funeral director W. C. Matheny & Sons
 Address Leonardtown Md

19. 12/15/45 Greenwell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from his last illness and that I last saw him alive on Dec 13, 1945

Immediate cause of death Coronary Thrombosis DURATION

Due to Arterial Sclerosis (hypertension)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Greenwell Coroner
 M. D. or other

Address Leonardtown Md Date signed 12/13/45

RECEIVED BY THE DEPARTMENT OF HEALTH

STATE OF NEW YORK

RM

DEC 19 1945

BUREAU V

DEC 19 1945

BUREAU V.R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County... *md.*City or town... *Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*St. Marys Hospital*How long in hospital or institution? *3 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *md.* County... *St. Marys*City or town... *Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Julia Mary Higgs

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov. 12, 1878

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

67

..... hrs. min.

8. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

John Bush

12. Name

John Bush

13. Birthplace

Colles Baine Hayes

14. Maiden name

Maryland

15. Birthplace

Mary M. Higgs

16. Informant

Leonardtown, Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof: *12/24/45*

(month) (day) (year)

Cemetery or crematorium

St. Francis Xavier

Location

St. B. Johnson

19. Funeral director

Leonardtown, Md.

Address

12/23

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 21* 19 *45* at *1:45 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 1945 to *Dec 21 1945*and that I last saw him alive on *Dec 20 1945*

Immediate cause of death

Cerebral Hemorrhage

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Paul A. Gussary

23. SIGNATURE

*Leonardtown*Address Date signed *12/23/45*

WASHINGTON STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE COUNTY OF KING

State of Washington

WEST VIRGINIA

RECEIVED
DEC 26 1945
BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town N. A. S. Patient Center Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina CountyCity or town Greensboro
 (If outside city or town limits, write RURAL and give nearest town)Street No. 816 Freeman Mill Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel B. Ingram

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Lilly Ingram

7. Birth date of

deceased (mo., day, yr.)

October 2, 1886

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

5926

hrs.

min.

9. Birthplace

North Carolina
 (Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Oliver B. Ingram

Address

116 C. St. N.W. Wash. D.C.17. Transportation
 (Burial, cremation, or removal. Which?)

Date thereof

12/10/45
 (month) (day) (year)

Cemetery or crematory

Location

Greensboro North Carolina

18. Funeral director

P. B. Robinson

Address

Leonardtown Md.

19.

12/9

19

45cinacis

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1945 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from didnot attend deceased 1945and that I last saw alive on Dec. 8 1945

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Circulatory changes &

Due to

over exertion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Francis F. Greenwell M.D.

Address

Leonardtown Ind.

Date signed

12/8/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

DEPT. OF HEALTH, BUREAU OF VETERINARY MEDICINE

CERTIFICATE OF RABBIT

RECEIVED

DEC 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Mary'sCity or town Academyville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary'sCity or town Rural Academyville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Chapman Maddox

3. (b) Social Security Number

4. Sex m 5. Color or race col 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 3-25-18588. AGE: Years 87 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Academyville
(Town, county, and state) Potomac10. Usual occupation Retired

11. Industry or business _____

FATHER 12. Name Gen. J. C. Maddox13. Birthplace St. Mary's CoMOTHER 14. Maiden name Jane Carey15. Birthplace Chaplin's16. Informant James MaddoxAddress Academyville17. Burial Date thereof 12-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation Burtonville, Md.18. Funeral director W. C. Weatherill & SonAddress Livermore, Md.19. 12-23-45 19 45 - R. V. Palmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23-45 at 5:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15-1984 to 12-28-1984and that I last saw him alive on 12-23-45 at 5:00 P. M.Immediate cause of death ChronichypertensionDURATION 5 yrs.Due to Chronic hypertension

Due to _____

Other conditions Coronary artery

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. Palmer

M. D. or other _____

Address _____ Date signed 12-23-45

RECEIVED DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 2 1946
BUREAU V.M.

Reg. Diat. No. 202

Address..... Leominster Date signed..... 12/8/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE DEPARTMENT OF JUSTICE

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DEC 11 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH

County St. Mary'sCity or town Leonardtown, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town R. 2041
(If outside city or town limits, write RURAL and give nearest town)Street No. Leonardtown
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Ellery J. Briem

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Susan Fargo Briem6. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) Aug 27 - 18818. AGE: Years 64 Months 3 Days 11 hrs. min.9. Birthplace Argusville Schosharie New York
(Town, county, and state)10. Usual occupation Lunch room

11. Industry or business

12. Name Jarvis J. Briem13. Birthplace Mechanic14. Maiden name Mechanic15. Birthplace Mechanic16. Informant Mrs. Susan Fargo P. BriemAddress Leonardtown Md17. Burial Date thereof Dec 12 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory State Hill New YorkLocation Sharon Hill New York18. Funeral director W. C. Martin, Inc.Address Leonardtown Md19. 12/10/45 C. C. C. C.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1945, at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 20 1945 to Dec 8 1945and that I last saw him alive on December 7 1945

Immediate cause of death

DURATION

Myocardial Failure over 3 monthsDue to Pneumonic Heart Disease ca 20 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Fuchs, M.D.
M. D. or otherAddress Leonardtown, Md. Date signed 12/9/45

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DEC 11 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: County..... <i>St Mary's</i> City or town..... <i>Catonsville, Md. near via St</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <i>visiting part of day</i> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... <i>Washington D.C.</i> (If outside city or town limits write RURAL and give nearest town) Street No. <i>17-5th St. S.E.</i> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <i>John P. Peck</i>				3. (b) Social Security Number			
4. Sex <i>M.</i>				5. Color or race <i>White</i>			
6. (a) Single, married, widowed, or divorced <i>Married</i>				6. (b) Name of husband or wife <i>Frances Harrison</i>			
7. Birth date of deceased (mo., day, yr.) <i>Oct 7-1890</i>				8. (c) If alive, give age <i>50</i> years			
8. AGE:				9. Birthplace <i>Swanton, Vermont</i> (Town, county and state)			
10. Usual occupation <i>Real estate agent</i>				11. Industry or business <i>Selling real estate</i>			
12. Name <i>Sidney Peck</i>				13. Birthplace <i>unknown</i>			
14. Maiden name <i>Josephine Lambert</i>				15. Birthplace <i>unknown</i>			
16. Informant <i>Frances Harrison Peck</i>				17. Address <i>17-5th St SE Washington D.C.</i>			
18. Burial, cremation, or removal (Which?) <i>Burial</i>				19. Date thereof <i>Jan 1/46</i>			
20. Cemetery or crematory <i>St. Calvary</i>				21. Location <i>New Hampshire</i>			
22. Funeral director <i>P.J. Saffell</i>				23. Address <i>475 H St. N.W. W.C.</i>			
24. (Date rec'd by registrar) <i>1/1/46</i>				25. Registrar <i>Caualier</i>			

MEDICAL CERTIFICATION

26. DATE OF DEATH <i>Nov. 31st 1945</i> at <i>90</i> M	
27. I CERTIFY that death occurred on the date above stated; that I attended deceased <i>did not attend saw the deceased</i> and that I last saw h..... <i>on Jan 12, 46</i>	
Immediate cause of death <i>Automobile</i>	DURATION
Due to <i>Automobile having been</i> <i>accidentally run into bank</i>	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings of operations	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
28. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide <i>Accident</i>	Date of <i>Nov 31, 1945</i>
Where did injury occur? <i>Catonsville, Md.</i>	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) <i>U.S. Air Base, Md.</i>	Means of injury <i>Automobile</i>
Injured at work? <i>no</i>	Signature <i>F. J. Greenwell, Coroner</i>
Address <i>Leonardtown, Md.</i>	Date signed <i>1-1-1946</i>

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JAN 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12673

Reg. Dist. No. 282

1. PLACE OF DEATH:

County..... St. Marys
 City or town..... Oakville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys
 City or town..... Oakville, Md. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Florence E. Perkins

3.(b) Social Security Number
none

4. Sex

female

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife..... James E. Perkins

7. Birth date of

deceased (mo., day, yr.)

June 16, 1906

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

39

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James C. Bankins

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Lee

15. Birthplace

Maryland

16. Informant

Juanita R. Courtney

Address

Oakville, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/29/45

(month) (day) (year)

Cemetery or crematory

St. Joseph

Location

Morganza, Md.

18. Funeral director

P.B. Robinson

Address

Leonardtwn, Md.

19.

(Date rec'd by registrar)

19

45

Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 45, at 1:00A PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Saw the deceased die Dec 27 - 1945
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Intercranial Hemorrhage DURATION

Due to

Fractured Skull

Due to

Automobile Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of Dec 27 - 1945Where did injury occur?..... near Oakville, Maryland
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... On RoadMeans of Injury..... Automobile Injured at work?..... No

23. SIGNATURE

P. B. Robinson

M. D. or other

Address..... Leonardtwn Date signed 12-27-45

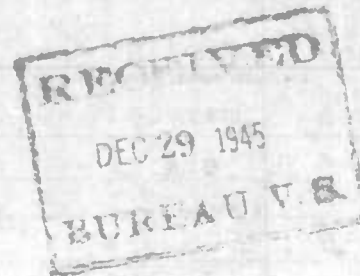
MARYLAND STATE DEPARTMENT OF HEALTH

STATE OF MARYLAND

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

12674

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary'sCity or town Germanville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. Mary'sCity or town Germanville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John A. Price

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) June 11, 19218. AGE: Years 24 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation laborer

11. Industry or business _____

12. Name Lester Price13. Birthplace Maryland14. Maiden name Annie Green15. Birthplace Maryland16. Informant Lester PriceAddress Germanville17. Burial Date thereof 12/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy FaceLocation Great Mills18. Funeral director P. B. RobinsonAddress Lionsdale19. 12/9 45 Accidental

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 7 1945 at 11:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from did notsaw body 1945 10 11:30 1945and that I last saw him alive on _____ 1945Immediate cause of death Cerebral Injury

DURATION _____

Due to gun shot wound

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of _____Where did injury occur? Camel Night St. Mary's Ind.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public placeMeans of injury Shotgun Injured at work? no23. SIGNATURE Francis F. Greenwell

M. D. or other _____

Address Lionsdale Date signed 12-5-45

CERTIFICATE OF DEATH

REC

DEC 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-6

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County St. Mary's
 City or town Hall Timbers (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. Mary's
 City or town Hall Timbers (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

Street No. L
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Ellen Jane Sheehan

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1858

8. AGE: Years Months Days If less than one day

87 10 30 hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

Louis Bean

13. Birthplace

Maryland

14. Maiden name

Amanda Stone

15. Birthplace

Maryland

16. Informant

Rose M. Sheehan

Address

Hall Timbers, Md.17. Burial Date thereof 12-19-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Georges

Location

Valley Lee, Md.

18. Funeral director

P. B. Robinson

Address

Leonardtown, Md.19. Dec 18 1945 P. J. Bean MD
(Date rec'd by registrar) (month) (day) (year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 5 1945 to Dec 16 1945and that I last saw him alive on Dec 15 1945

Immediate cause of death

General ataxia cerebelliIntestinal stasis(partial obstruction)Due to Partial intestinal obstruction due to constrictive band due to cancer surgery

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE P. J. Bean MDAddress Great Mills, Md.Date signed Dec 18/45

M. D. or other

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DEC 22 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

Reg. Dist. No. 126725-1

1. PLACE OF DEATH:

County St. Mary'sCity or town Rural Bushwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary'sCity or town Rural Bushwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Josephine Gamm Shingler

3. (b) Social Security Number

4. Sex fm. 5. Color or race w 6.(a) Single, married, widowed, or divorced married8.(b) Name of husband or wife Thomas Ross Shingler8.(c) If alive, give age 71 1/2 years7. Birth date of deceased (mo., day, yr.) 6-24-18768. AGE: Years 69 Months 6 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Chaptais md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name William G. Gamm13. Birthplace Chaptais md14. Maiden name Lowet Thomas Gamm15. Birthplace Chaptais md16. Informant Thomas Ross ShinglerAddress Bushwood md17. Burial Date thereof 12-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LouisLocation St. Louis18. Funeral director McMurry & SonsAddress Temadome md19. 12-28 19 45 R. V. Palmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-1945 at 1:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 19 43 to 1945and that I last saw him alive on 12-28-1945Immediate cause of death Heart attackDue to DiabetesDue to Gen. debilityOther conditions Indigestion of food

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. PalmerAddress St. Mary's Date signed 12-28-45

M, D. or other

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

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JAN 3 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-5

CERTIFICATE OF DEATH

Reg. Dist. No. 12577 282

1. PLACE OF DEATH:

County St. Mary'sCity or town Loneville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Loneville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hennitta J. Somerville

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced widowed

B.(b) Name of husband or wife _____

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 1, 18768. AGE: Years 69 Months 8 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation none

11. Industry or business _____

12. Name Sandy Herbert13. Birthplace Maryland14. Maiden name Hennitta Ficks15. Birthplace Maryland16. Informant Bernard SomervilleAddress Loneville, Md.17. Burial Date thereof 12/27/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JosephLocation Maryland18. Funeral director B. B. RobinsonAddress Leonardtown19. 12/26 19 45 Cannell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1945 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Dec 25, 1945 and that I last saw him alive on Dec 23, 1945

Immediate cause of death _____ DURATION _____

Chronic Myocarditis

Due to _____

Due to _____

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Paul G. Cannell M. D. or other _____Address Leonardtown Date signed 12/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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DEC 28 1945
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12678

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town Lovenville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lucy V. Sammons

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife JAMES F. Sammons6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) 1913?

8. AGE: Years 32? Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name James Thomas13. Birthplace Maryland14. Maiden name Lucy V. Branson15. Birthplace Maryland16. Informant James F. SammonsAddress Lovenville, Md.17. Burial Date thereof 12/24/45
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory St. Joseph Cem.Location Morgantown, Md.18. Funeral director R. B. RobinsonAddress Leonardtown, Md.19. 12/23/45
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. Mary'sCity or town Lovenville, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 10:00 AM21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec 21 1945 to 21 1945and that I last saw him alive on Dec 21 1945Immediate cause of death Sudden death DURATIONProbably Coronary ThrombosisDue to Myocarditis (from history)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Paul P. Cunniff

M. D. or other _____

Address Leonardtown Date signed 12/23/45

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DEC 26 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County St. Mary'sCity or town St. Mary's
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45-7

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary'sCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(e) If veteran, name war _____

3. (a) FULL NAME

Thomas Thomas

3. (b) Social Security Number

4. Sex m5. Color or race wh6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife James A. Thomas

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 8-15-1871

8. AGE: Years Months Days If less than one day

74 4 14 hrs. min.9. Birthplace Prince George's and

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

FATHER 12. Name William H. Taylor13. Birthplace St. Mary's CoMOTHER 14. Maiden name Clara Thomas15. Birthplace St. Mary's Co16. Informant Louisa BallbarstAddress 823 Euclid St. NW Wash DC17. Burial Date thereof 1-3-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lacerd HeartLocation Bushwood18. Funeral director McWaters & SonsAddress in addition to19. 1-1- 19 45 Robert V. Palmer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 19 45 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct-10 19 45, to Dec-29 19 45and that I last saw him alive on 12-29 19 45Immediate cause of death EndocarditisChronic DURATION 6 mosDue to chronic infectiousmyocarditis 3 yrsDue to exhaustioninability toOther conditions none

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. Palmer

M. D. or other

Address in addition to Date signed 1-2-48

RECEIVED

RECEIVED

RECEIVED

JAN 4 1946

BUREAU V &